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Education and training on substance use disorders: Recommendations for future national Drug Policies

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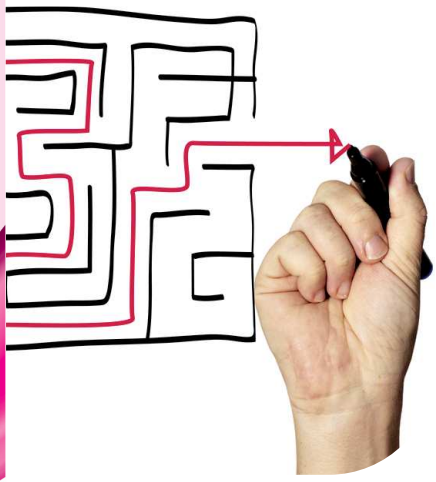

Education and training on substance use disorders

P-PG /Res-Edu (2013) 4

Recommendations for future national Drug Policies

By the Working Group
on establishing education and training programmes
in the field of addictions

Pompidou Group
Groupe Pompidou

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

Co-operation Group to Combat Drug Abuse and Illicit trafficking in Drugs

French Edition:
Education et formation aux troubles liés à l'usage de substances
Recommandations pour de futures politiques nationales en matière de drogues

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The Pompidou Group

The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) is an inter-governmental body formed in 1971. Since 1980 it has carried out its activities within the framework of the Council of Europe. 35 countries are now members of this European multidisciplinary forum, which allows policy-makers, professionals and experts to exchange information and ideas on a whole range of drug misuse and trafficking problems. Its mission is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in its member states. It seeks to link policy, practice and science.

Through the setting up in 1982 of its group of experts in epidemiology of drug problems, the Pompidou Group was a precursor for the development of drug research and monitoring of drug problems in Europe. The multi-city study, which aimed to assess, interpret and compare drug use trends in Europe, is one of its major achievements. Other significant contributions include the piloting of a range of indicators (Treatment Demand Indicator) and methodological approaches, such as a methodology for school surveys, which gave rise to the ESPAD (European School Survey Project on Alcohol and other Drugs [1]).

The research platform has superseded the group of experts in epidemiology, active between 1982 and 2004. There has been a change of function from developing data collection and monitoring methodologies to assessing the impact of research on policy. This started with the holding in 2004 of the Strategic Conference on linking research, policy and practice – Lessons learned, challenges ahead, which identified the lack of exchange of knowledge as a major gap.

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1 *See Pompidou Group list of documents and publications at the end of this publication*

The research platform's primary role was to better support the use of research evidence in policy and practice, thus facilitating the development of evidence-based policy. Moreover, it also signalled the latest issues that arose from drug research in the social and biomedical fields and promoted interaction between research disciplines such as these and psychological drug research. Reports on these subjects have been published and can be viewed in the appendix.

Following the mandate by the ministers for the 2011-2014 Pompidou Group work programme at the Ministerial Conference in November 2010, the research platform has now been superseded by expert groups related to specific topics in particular coherent policies. The activities per se follow on from an initial request from Greece during a Mediterranean Network meeting to address the issue of education and training in the field of addictions. The outcome in part is the paper herein and the eleven relevant recommendations that have come to the fore following the discussions by the expert group.

Contents

Background

1.1 The problem

Substance use disorders (SUDs) are preventable and treatable medical conditions that have a major impact on public health as well as the social and economic well-being of the individual and society at large. Related morbidity and mortality rates are very high worldwide and addictive substances rank high in the Global Health Risks report of the World Health Organisation (WHO 2009a). The size of the problem is evident from the best estimates of persons suffering in the EU from alcohol dependence (14.6 million), opioid dependence (1 million) and cannabis dependence (1.6 million) (Wittchen et al. 2011).

The scope of the problems resulting from SUDs is not met by an appropriate availability of programmes and services; coverage of the population in need with alcohol and drug use disorder treatment services is low. Only 10% of opioid-dependent people worldwide have access to care, and this minority is spread across the 40% of countries that provide treatment services for injecting drug users (WHO 2010). Even in countries with high resources, the quality of services is frequently deficient (McLellan et al. 2003, Haasen et al. 2004).

As in other medical fields, the efficiency and effectiveness of interventions depend on the availability of competent staff. Professional competence stems from research-based education and training as well as empathic patient-friendly attitudes and responding to the individual needs and expectations of patients. In the case of substance use disorders this includes encouragement and empowerment of patients to take care of themselves (Oliver et al. 2004). Cooperation with self-help efforts improves the outcomes (Humphreys and Moos 2007). Such competences can be learned.

Most people with substance use problems are not seen by specialists, but in general practice, by family doctors, in social services, in hospitals and emergency rooms. These staffs also needs adequate understanding of substance use and substance

use disorders in order to recognise them and provide helpful advice, brief interventions and referral for treatment (Caner et al. 2013). This is another type of competence, but equally important, and it too can be learned. Consequently, there is a growing body of evidence to support the argument that all health care providers should demonstrate such competences. Despite the emerging consensus, not all the guidelines and training programmes are satisfactory in relation to outcome evaluation (Uchtenhagen et al. 2005). Moreover, the existing literature describing such SUD curricula has been criticised for its lack of systematic assessment data to support specific educational approaches and evaluation.

1.2 A European deficit

Training in the addiction field in different countries covering the European region has demonstrated that common standards on addiction training based on evidence are required. I-ThETA[2] looked into this very aspect and has reported that where training exists, at best, it is not coordinated at national level, and at worst, there are only a few training possibilities offered by NGOs. The training in addiction is rarely integrated into official training structures, leaving the addiction field in the margins of the training system that exists for the main disciplines concerned (psychiatry, psychology, social work and nursing care) (Uchtenhagen et al. 2008). Moreover, taking into account the different legislative frameworks that govern drug policy and the national cultures that exist in relation to the representation of the drug phenomenon, it transpires that to date, no minimum standards are in place with respect to training in the addiction field.

A recent EU project to identify minimum quality standards in drug demand reduction (EQUS) established lists of minimum standards on the basis of relevant national and international guidelines and other publications, and submitted the lists to an extended number of stakeholders online and during a European Conference. This consensus building process resulted in definite lists of standards that received 80% of consensus or more. At the same time, a major deficit in implementing the accepted standards at national level became obvious. Implementing shared quality standards in drug policy and interventions will include major efforts in education and training (Uchtenhagen & Schaub 2012).

Similar deficits in addictology training are described in the USA (Isaacson et al. 2000, Rasyidi, Wilkins and Danovich 2012).

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2 *I-ThETA: International Think Tank – Education and Training on Addiction*

1.3 The mandate of the working group on addictology programmes

This group was set up following an appeal for the creation of an addictology diploma to meet the training needs of medical and paramedical staff in Europe and the Mediterranean Region. This appeal was launched by the Permanent Correspondent from Greece during a MedNET meeting in June 2011. It was suggested that this issue of training on addictions be addressed not only by the MedNET member countries but also by other member countries of the Pompidou Group that would be interested in the topic.

During the first meeting of the working group in October 2011 in which the issue of the different countries' existing addictology programmes was discussed, it was evident that not all countries were in a position to satisfy the necessary requirements for those involved in the field of addiction.

As a result, the outcome of the meeting provided the impetus for the preparation of the terms of reference for which the issue of education and training in relation to drug policy was formulated. This work proposal was accepted by the MedNET committee in Brussels in November 2011.

This expert group followed this work proposal / terms of reference, which was submitted to the Pompidou Group Permanent Correspondents for acceptance.

According to the proposal, the group is to prepare a framework that incorporates the objective of education and training into the mainstream of policy and practice (see terms of reference P-PG/Res/Education (PG 2011)).

2

The strategic objectives

Taking into account the different legislative frameworks that govern drug policy, diverse national cultures and the resultant representation of the drug phenomenon, the existing training systems and the state of progress concerning addiction training, it soon became apparent that the group was not in a position to simply draft recommendations for a training programme. Therefore, the working group agreed on three strategic objectives.

2.1 Integration of addictology programmes at national level

The first objective is to put the topic of education and training on the agenda of each national drug policy and to integrate such programmes in the mainstream of their educational systems. It is a long-term objective, but it should guarantee the sustainability of the results.

2.2 Comprehensive concept for national training policy

The second objective is to develop a general concept that describes the different elements taken into account during the formulation of a national training policy. This document, which emphasises the different strategic challenges, should serve as a reference framework for national policymakers for the formulation of those policies. This document should allow for a flexible and long-term training policy that takes into account the different national contexts.

2.3 Integration of addictology programmes at EU level

Finally, the third objective is to encourage the EU to include the topic of addiction training in the new EU strategy on drugs, possibly on the basis of the document drafted by the working group.

To date, the working group on the introduction of education and training in the addiction field has managed, through Professor Meni Malliori, Permanent Correspondent for Greece, to influence the new EU Drug strategy 2013-2020 adopted on 11 December 2012, which includes in the last point 28.8: 'Ensure and reinforce training of professionals involved with drug related issues, both in the demand as well as the supply reduction field' (EU 2012).

3

International legal and political framework

3.1 Legal basis: UN conventions

The Single Convention of 1961 urges signatories in article 38 'to take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved' (UN 1961).

With respect to having adequate trained staff to do the necessary skilled job in the area of addictions, the United Nations 1971 Convention, namely article 20, states the following (UN 1971):

1. The Parties shall take all practicable measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, and shall co-ordinate their efforts to these ends.
2. The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of psychotropic substances.
3. The Parties shall assist persons whose work so requires to gain an understanding of the problems of abuse of psychotropic substances and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of such substances will become widespread.

The UN Convention on the Rights of the Child seeks to protect children from the use of psychoactive substances (UN 1988) and the Convention on the Rights of Persons with Disabilities (UN 2006) includes the right to health among a number of other rights.

3.2 Ethical basis: human rights (Council of Europe)

A training and education policy also has to be based on the respect of human rights. Hence, the key element here is the Convention for the Protection of Human Rights and Fundamental Freedoms, as put forward by the Council of Europe in 1951 (CE 1951). The convention outlines, in a number of articles, core issues that aim to protect the individual by the rule of law; these include the right to life, the prohibition of inhuman or degrading treatment, slavery and compulsory labour, as well as discrimination in a number of domains (Articles, 2, 3, 4, and 14).

Moreover, the Convention on Human Rights and Biomedicine, introduced by the Council of Europe in 1997, seeks to protect the 'dignity and identity' of all human beings and respect the rights and freedoms with regard to the application of biology and medicine. This also entails 'equitable access to health care' in addition to 'free and informed consent' (CE 1997).

These conventions thus provide the rationale for the development of educational resources that will provide users of psychoactive substances the service they require as a right and not merely as an afterthought. Consequently, providing such services, be they primary, secondary or tertiary care, requires trained personnel at the different levels of expertise to ensure that each service is covered by staff with the relevant competences.

3.3 Rights to health standards (Universal Declaration of Human Rights, Covenant on Economic, Social and Cultural Rights, WHO)

The Universal Declaration of Human Rights (UN 1948) contains, among a number of relevant conditions, the right of equal access to medical care and social services (art. 25/1),

Article 12 of the Covenant on Economic, Social and Cultural Rights states (UN 1976):

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The rights to health standards and the indiscriminate access to health and social care cannot be achieved in practice without appropriate shared education and training of the professionals involved. However, a report by the International Union for Health Promotion and Education for the European Commission mentioned that training alone produces a relatively small return on investment, and efforts should be directed at organisational changes that facilitate greater use of evidence-based care which will promote population health whether the interventions concerned are preventive or curative. There is also a need, in many countries, to re-orientate medical and nurse training to produce a greater emphasis on prevention.

The World Health Report 2006 is dedicated to the problems and principles of workforce development in health services. In addition to appropriate training and continuing education it mentions other necessities. In Chapter 2 on 'urgent health needs' it enumerates some of the main problems as follows (WHO 2006):

- Inappropriate or inadequate training, with curricula that are not needs-based
- Poor access to information and knowledge resources
- Uneven distribution of workers at different levels of service delivery, from national programme officers through to health facility personnel
- Poor policies and practices for human resources development (poor career structures, working conditions and remuneration)
- Lack of supportive supervision
- Lack of integration of services with the private sector

The WHO Plan of Action for the period 2006-2015 states: 'the goal in all countries is to build high-performing workforces for national health systems to respond to current and emerging challenges. This means that every country should have implemented national strategic plans and should be planning for the future, drawing on robust national capacity. Globally, a full range of evidence-based guidelines should inform good practice for health workers' (WHO 2006).

4

Scientific justification of education and training in the field of addiction

4.1 The role of research evidence

Education and training is not a goal in itself. It is instrumental for achieving good outcomes in prevention and treatment. This implies reviewing and continuously updating the results of research evidence on the effectiveness and efficacy of approaches, methods and programmes used in prevention and treatment, as a basis for promising good practice. However, every country will have to make choices among the various approaches and programmes, according to the type and prevalence of drug problems and to the availability and structure of health and social services. Therefore, education and training has to consider two tasks: to qualify the workforce on the basis of available research evidence, and to tailor approaches and programmes to the available resources.

4.2 Reviews of evidence

The body of scientific knowledge in drug prevention and treatment has increased considerably over the last decades. At the same time, preventive and therapeutic methods have been diversified. Research results are at times controversial, depending on the variability of target populations, methodological procedures and interpretation of findings. Rigorous standards had to be developed for analysing studies and for establishing meta-analytical methods, comparing multiple studies in a systematic review. Internationally, two organisations have been established in order to review and analyse evaluation studies selected for their rigorous methodology: the Cochrane Collaboration and the Campbell Collaboration (links under References below).

The Cochrane Collaboration has its focus on evaluation of medical treatments, while the Campbell Collaboration has its focus on social interventions. Both organisations make their reviews available in their respective online libraries. A growing number of reviews cover pharmacological and psychosocial treatments in addiction and their outcomes.

Not all issues in prevention and treatment have been studied or are even able to be studied with the most rigorous comparative methodology, the randomised controlled trials (RCT). A grading scheme of evidence (GRADE working group 2004) helps to classify research results according to their scientific value and thereby facilitates the inclusion of a range of methodological different studies into an overall review that can be used as a guideline for good practice. One example is the WHO international guidelines on psychosocially assisted pharmacological treatments of opioid dependence; its recommendations differ in strength and the evidence behind the recommendations is also graded. A further differentiation is made by formulating minimal requirements (WHO 2009b).

Many guidelines are not or not only based on scientific evidence, but on expert opinion and experience. This is open to bias and criticism. In order to minimise these disadvantages, strict methods have also been developed for consensus building among experts, allowing for a qualified representation of clinical experience. One example is the quality standards for drug prevention, on the basis of the AGREE II methodology (AGREE II 2009).

4.3 Consensus on minimum standards for interventions (EQUS project)

An attempt to provide minimum quality standards in demand reduction has been made by the EU. In effect, as a result of the EQUS project, in which the issue of quality was put at the forefront, a final list of proposed minimum standards was made in which 33 standards were identified for prevention, 22 standards for treatment and rehabilitation and 16 standards for harm reduction. Under prevention, P6 and P23, treatment/rehabilitation, TR6, TRs15 and TRil5, and harm reduction, HR2 and HR11, relate to adequately qualified staff to run the services in question (Uchtenhagen & Schaub 2011). The EU is expected to provide funds for facilitating the implementation of these minimum quality standards in 2013, as these as yet are not in place.

5 Premises for a general concept

5.1 Understanding substance use disorders and care options

There is no uniform understanding of addictive behaviour. Various paradigms apply here: the use of psychotropic substances can be understood as self-medication for symptom relief (Khantzian 1997), as a special variation of self-manipulation, tailoring use to a desired state of mind, or as instrumental for self-enhancement, optimising function and output (Harris 2007). Or else, substance use is understood as a lifestyle phenomenon, in the sense of 'consumerism' or of an expression of sub-cultural identity. On the other side of the coin, addiction can be understood as a brain disease, with repetitive substance use resulting in structural brain changes (Leshner 1997), or on a vulnerability-stress model focusing on the impact of genetic and environmental factors on the brain changes (Volkow et al. 2004). All these paradigms are backed up by some research evidence and have an impact on the choice of therapeutic options. Efforts to build an overall understanding in a comprehensive theory of addiction have been made, bringing the various elements together in a synthetic framework (West 2006). Also, the various addiction trajectories in contemporary societies and their consequences have been analysed (Raikhel and Garriott 2013). Finally, it is also apparent that co-morbidity with other psychiatric disorders is common in addiction, with some two-thirds of the cases having such a co-morbid condition.

Understanding addiction as a chronic relapsing disorder has consequences for intervention strategies (McLellan et al. 2000) as well as for community perception and acceptance, for policy-making and for the access to care. However, evidence on spontaneous recovery from drug dependence encourages interventions focusing on facilitating self-help potentials (Klingeman and Sobell 2007), and lessons can be learned for successful treatment approaches.

This means, in essence, that addictive behaviour is not homogeneous with regard to causal factors, risk constellations and recovery potential. Each individual case has to be considered for its individual needs and responsiveness. Education and training must enable professionals to understand this diversity without undue bias, and to provide a broader view of pathways into and out of drug related conditions.

5.2 Adaptability of the concept to national contexts

A training and education policy should be an integral part of a national drug policy as exemplified in the new EU Drugs Strategy 2013-2020. At its best, it is fixed in the national legislation, as for example in Switzerland. The training of professionals responsible for drug addiction issues is a key element of professionalization in this field.

A training and education policy should be adapted to the legislative and structural context of each country. The question of, for instance, whether a training system should contribute to create a new profession (addictologist) or whether it should give new tools to the professions already involved to add new abilities in addiction, is a national political decision.

Consequently, a training policy should be based on the analysis of the specific national context and training needs in a given country.

5.3 Addressing all concerned actors in prevention and treatment

Preventive efforts as well as early recognition and interventions, support for treatment and rehabilitation programmes, and acceptance of addicts as candidates for re-integration into the labour market and into society at large cannot take place without a comprehensive approach involving all types of actors.

A national training policy should therefore address four target audiences: the professionals who are dedicated full time to dependent patients (specialists in addiction or addictologists), the professionals who are occasionally concerned with dependent patients (e.g. primary care physicians, emergency services practitioners, social workers, nurses at a general hospital, police officers, teachers, prison staff),

along with voluntary workers and peers from civil society and the Church, for example, as well as members of society in general.

This approach reflects the idea that addiction affects essentially the whole of society, and it cannot be delegated to specialist professionals alone.

5.4 Treatment diversity and treatment needs

Each society and culture may have its own mixture of addictive behaviours, with some being more influenced by alcohol and others by illegal drugs or tobacco. The epidemiology data provide information about which problem one might wish to address first, and this will have an influence on which training strategy will be chosen.

At present, priorities in prevention and treatment approaches are also determined by traditional attitudes and ideological preferences. This can be seen especially in the preference of prevention, treatment, harm reduction or repression. In Europe however, such differences are in the process of being replaced by a more uniform policy, as proposed by the EU drug strategies and drug action plans. An analysis of the situation is provided by EMCDDA, based on information from the national focal points, in its annual reports (EMCDDA 2012).

The need for preventive interventions depends largely on epidemiological data (incidence and prevalence of addictive behaviours, type of populations at risk) and on qualitative knowledge about attitudes in the target populations. Such indicators help to formulate priorities for future types of prevention (universal, targeted or indicated prevention).

The type and extent of treatment needs also depend on the specific situation at national level. They can be approximated by comparing epidemiological and treatment data, but also by taking police data, waiting list data, and information from key informants into consideration. In general, the broader the spectrum of preventive and therapeutic approaches, the more likely the persons with addictive behaviours will be reached and will find an acceptable treatment.

The need for harm reduction approaches is mainly determined by documented negative consequences of drug use and abuse in a country. Both health and social consequences are to be considered here.

It is recommendable to shape education and training in response to national priorities and intervention needs.

5.5 A continuing model of interventions

Treatment approaches and programmes, as well as prevention programmes, have been developed in most countries in response to needs, without systematic planning at the national level, and they had to establish themselves in the framework of a competitive market. Inevitably, this situation has contributed to ideological and practical fights. The best known examples are the controversies between abstinence-oriented and agonist maintenance treatments of opioid dependence, between recovery-oriented and harm reduction approaches, between programmes aiming at total abstinence and those aiming at reduction and change in consumption style and extent.

Increasingly, research results support a concept of complementarity of approaches rather than exclusiveness. The diversity of persons engaging in addictive behaviours calls for a diversity of approaches, and the leading question is no longer 'Which approach is best?' but rather 'What is good for whom?' The result is a concept of an integrated service system.

A good example is the British model of an integrated system for drug services, issued by the Beckley Foundation (Stevens et al. 2006). It covers the whole range from low threshold harm reduction approaches to structured treatment programmes and stresses the need for coordination.

Educational programmes will need to be conceived on the above premise.

5.6 A step-by-step procedure

A starting point for developing a national policy for education and training could be an analysis of the present situation and the identification of priority needs. The next step is a concept of appropriate interventions responding to priority needs, with a preference for well-documented and evaluated approaches. Experimentation and careful evaluation of experiments could be helpful in order to deal with specific challenges.

Problems with addictive behaviours will change over time: new substances, new consumption patterns and preferences, and new target populations may surface. Preventive and therapeutic responses must be open to adaptations in order to meet the new problems, and education and training must prepare all actors accordingly.

6

The general model for education and training

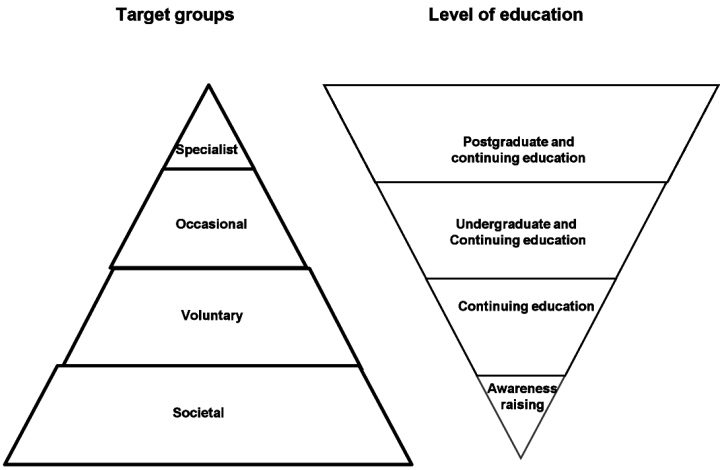
6.1 Why a general model?

These premises all come to the same conclusion: no single education and training programme will be adequate for the specific problems in the various countries. Therefore, the working group decided not to present a fixed training programme but rather to develop a general model to establish a long-term training and education policy that emphasises the different elements to be considered and that can be used as a reference for establishing such a policy in each country.

6.2 The hierarchy model of target groups and educational level

The general model emphasises that all target groups should be addressed but at different levels of knowledge and skills, starting at the bottom with a general understanding of the addiction phenomenon by important actors in society such as politicians, policymakers, journalists, etc., up to addiction specialists who need full knowledge of and competences on prevention, treatment and harm reduction. Other concerned professionals who occasionally meet dependent patients in their specific function, for instance nurses at a general hospital, social workers in an organisation for unemployed people, or church voluntaries working in an organisation for homeless people, need to receive appropriate training. WHO has for a long time stressed the importance of well-trained generalists (non-specialists) in health care (WHO 1996).

The general model does not mean that each target group should be addressed at the same time. Each national policy will define its own priorities. The general model provides an overview and framework.



6.3 Defining target groups and levels of education

A **specialist** is a professional working exclusively in the field of addiction. Specialists usually have an undergraduate qualification in medicine, social work, psychology, nursing or other health care/social science as well as the necessary postgraduate qualifications in the relevant fields. Specialists need continuing education in order to update their knowledge of relevant new research and of intervention options. Three levels of education apply:

- ***Undergraduate education*** covers basic education in the main professional fields directly or occasionally involved with addicted patients: medicine, social work, psychology, nursing, etc. Specific aspects of addiction (medical, psychological, social) can be differently highlighted according to each specific specialty. In addition, they should cover the bio-psycho-social model of addiction. This will provide students with a more accurate and comprehensive approach regarding addictions in general, have the propensity to decrease the stigma related to addictions (which is a priority, at least among specialists), and increase students' awareness of and interest in addictions, which in turn may facilitate the prospect of their continuing to work in this field in the future.

- ***Postgraduate education*** applies to specialise curricula on addiction that follow on from basic education at undergraduate level, mainly in social work,

psychology, medicine and nursing. Postgraduate curricula can be – according to the European Bologna Model – of a different level and issue a certificate, a diploma or a Master's degree. The major objectives are to develop relevant knowledge on psychotropic substances and interventions, skills in assessment, intervention planning and provision, and appropriate attitudes and behaviour.

- ***Continuing education*** applies to all kinds of short courses, workshops, participation in conferences etc., giving no special qualification, but knowledge and skills focused on specific issues. For some specialists, continuing education is compulsory, measured by credits, without which they may not keep their specialty qualification.

Through examples we can note how the situation differs with regard to the educational system of the country. In the Czech Republic, for instance, the specialists are educated at undergraduate level in a specialised centre dedicated to addiction education. On the other hand, in Switzerland, the specialists are educated at postgraduate level. A certificate, diploma or Master of Advanced Studies is issued by universities of applied sciences.

An **occasional** is someone working as a social worker, nurse, psychologist, psychiatrist, general practitioner, policymaker, judge, civil servant, police officer etc. and is occasionally confronted in his or her respective jobs by individuals with addiction problems. Two educational levels apply:

Undergraduate education provides a basic understanding of the addiction phenomena, an appropriate attitude towards patients or clients, and the necessary skills for the function required by the post. Major qualifications allow one to recognise problems of substance misuse or addictive behaviour, to provide advice and possibly early interventions, and to know about indications and procedures for referral to a specialist.

Continuing education offers an update in relevant new knowledge about issues learned in undergraduate education, or provides complementary knowledge needed for competent performance and professional functioning in post.

A **voluntary** is someone dedicated to helping addicts for different kinds of personal reasons who gives some time to an organisation active in this field. Ideally such an individual would have undertaken some courses in continuing education focused on the function and tasks required.

Continuing education mainly enables these persons to develop non-judgmental attitudes in dealing with people with substance related problems, to be unafraid and open to their problems, and to cooperate effectively with occasionals and specialists.

Societal is to be understood as a comprehensive term for all kinds of people not as directly confronted with addicts in their professional life as the three first target groups but dealing with addiction issues, for instance a journalist, a jurist formulating a law, a person involved in service planning or supervision, a politician or other persons involved in activities which have a bearing on the care of people with substance use problems. They need some basic information related to their societal function and duties, raising their awareness of existing and potential problems.

Awareness raising applies to all forms of communication aimed to make the addiction phenomena more understandable for the aforementioned target groups and for advocacy.

Continuing education for specific groups of societal focuses on the specific functions of members of society for discussing or shaping issues in regard to addictions (e.g. policymakers, Members of Parliament).

6.4 Providers of education and training

Education and training are provided by different structures and organisations. According to a European survey in 2004, professional associations and universities have a dominant role in developing educational programmes, and providers operate in free market competition rather than in a guided structure (Uchtenhagen et al. 2008). It seems that there is a deficit here and that state-commissioned organisations are increasingly working on filling the gaps in a number of countries. Thus the issue that arises here is one of recognition as well as the infrastructure through which such initiatives are embedded in the education system per se.

With reference to the general model, we can note that universities (academic higher education) or universities of applied sciences (vocational higher education) are appropriate for undergraduate and postgraduate curricula. NGOs or professional associations are more appropriate for continuing education. To define which provider is the appropriate one, it is necessary to consider following criteria:

- to position the course on the educational map (legitimacy, level of education, etc.)
- to position the addiction field on the professional map.

6.5 Determining needs for education and training

A needs analysis will have to be taken into account when assessing the level of education of those involved in delivering prevention, treatment, harm reduction and social re-integration services. Different methods exist to carry out a needs analysis. Needs analysis can be done on different levels, depending on what already exists on the market: on the highest level to establish an education policy or on the lowest level to create a course or a curriculum.

The following questions should be addressed, depending on the level:

- Who is the target group and what it is the size of this group?
- What level of education is required?
- What functions and which fields of activity are to be addressed?
- What are the key competences of the functions or activities concerned?
- Which institutions are potential providers?

Today, no consensus-based instruments exist for an appropriate needs assessment in this area. Developing, testing and evaluating such instruments would be helpful and supportive for the overall aims of this initiative.

6.6 Methods used for education and training

The literature offers a wide range of educational methods to train medical and non-medical professionals in the field of substance use disorders. Of all the instructional strategies, some showed the different interventions to be equally effective in improving short-term outcomes. In general, the more effective modalities are those which are active and experiential, such as structured role-play with standardised patients who function as instructors. This finding is consistent with the related medical-education literature on tobacco, which suggests that the most effective curricula emphasise active practice of skills over passive instructional methods. The most common type of teaching programme in the field of SAD is a series of theoretical courses over a rather long and scattered period of time with a

practical immersion in a specialised centre. Courses over a long period of time seem to be effective for health professionals as part-time trainers.

In addition, it appears that:

- Intensive and immersive treatment programme experiences (e.g. one week spent participating in a range of activities at a drug and alcohol treatment programme) seem specifically to improve the regard for patients with alcoholism and SUD, which is an important component of providing effective care to this population.
- Computer-assisted courses, which are relevant and practical, can efficiently increase knowledge and motivation for further learning about SUD. This instructional strategy is easy to scale up to large numbers of learners, which increases its educational impact.
- SUD curricula must include all aspects of drug use. The more comprehensive the course, the greater the knowledge. Retaining of knowledge and skills is highly attributable to the capacity to practise on the ground. Early enrolled professionals in specialised programmes are more likely to be more effective. Moreover, the training of ex-addicts/users is also one aspect that needs to be addressed in light of their experience and their willingness to be involved in drug prevention and treatment.

6.7 Evaluation and quality control

The aim of curricula in SUD is mainly to improve knowledge, skills, and self-efficacy of trainees. These curricula have improved over the last decade, especially with new epidemiological, neurobiological and genetic innovations. Also, particular attention is paid to building a rigorous evidence-based medical education and teaching practice.

In principle, evaluation can be made on different levels, in regard to reactions, learning outcomes, behaviour and results/effects (Kirkpatrick 1998). In practice, tools and instruments used to evaluate SAD trainings are mainly based on trainees' satisfaction; an exception focusing on the impact of training on the work and status of trainees is documented in Germany (Meyer 2004). Many scales have been used to measure the level of satisfaction. However, more work needs to be done to establish the reliability, validity, and feasibility of these instruments. However, simple tools could be used to evaluate a course or diploma:

Immediate outcomes:

- Number of enrolled trainees
- Rate of satisfied demands
- Trainees' satisfaction regarding the different courses
- Trainees' satisfaction regarding the practical training

Mid-term outcomes:

- Documented sharing of knowledge and skills with staff in the workplace
- Documented applicability in daily practice in the workplace

Long-term outcomes:

- Training outcomes in terms of career impact, job opportunity, job orientation…
- Training outcomes in terms of public health positive response (acknowledging training value, utilisation of newly qualified trainees…)
- Perceived added value of the training for the professionals and policy-makers

In a European context, evaluation of continuing education and training would profit from a standard instrument measuring the various outcomes at defined end-points, in order to allow for comparative data as a starting point for improvements. No such instrument is available for the time being, and its development, testing and evaluation would facilitate the overall goals of this initiative.

7 Characteristics of addictology training programmes

7.1 Undergraduate curricula

Each of the undergraduate curricula of the four main professions concerned with addictions (medicine, social work, nursing and psychology) should include courses on addiction, designed from the perspective of the field concerned, but showing the inter-disciplinarity of the issues. This addiction course could be a bloc course of a week, to allow the students to immerse themselves in the complexity of the addiction phenomenon.

Examples:

> One US proposal is to start training on addictions early in the medical student's career and to continue in a vertical integrated way throughout medical school. Students are to be given multiple opportunities to learn and use screening interviews for addiction in preclinical courses, and in continuing medical education the faculty has an opportunity to share knowledge as well as to serve as role models (Klamen and Miller 1997).
>
> A US national survey found that less than 10% of the faculty in undergraduate training for substance use problems had experience in alcohol and drug treatment programmes and reported a definite need for additional faculty development programmes for themselves (Fleming et al. 1999). The conclusion is that there is a need for training the trainers by addiction specialists. A similar conclusion comes from a recent review of substance use training programmes (Polydorou et al. 2008).

7.2 Education and training for specialists

Within specialised courses on prevention, treatment and harm reduction, each of the curricula should give general and contextual knowledge on the phenomena of consumption of psychotropic substances, of use and addiction:

- Historical, anthropological and sociological aspects: cultural perception of consumption, abuse and addiction at national level and the structures involved, and if possible in comparison with other countries/cultures
- Legal aspects: international and national legal frameworks that regulate the consumption of psychotropic substances, together with those that regulate human rights and health legislation
- Ethical aspects and resulting consequences (stigmatisation, etc.)
- Epidemiology of consumption, abuse and addictions relating to different substances and addictive behaviours
- Economic issues relating to consumption, abuse and addictions
- Pharmacological aspects: the substances and their effects
- Neurobiology and genetics of addictions
- Causes and concepts of addictions and behaviour

Special issues at the personal level (reflexive work):

- Own perception of addictions and personal beliefs on addiction
- Substance use and addiction in one's own family
- Co-dependency patterns

Examples:

UK: An advanced example of postgraduate education in addictology has been developed by a working group at the UK medical royal colleges, regarding the core competences needed by all postgraduate specialist trainees on substance misuse (Morris-Williams et al. 2012). The core competences are threefold:

1. Knowledge (effects, potential harm and addictive potential of psychotropic substances; range of interventions and prognoses; recommended limits of alcohol intake)
2. Skills (assessment including co-morbidities; providing advice and early interventions: referral indications and procedures)

3. Attitudes/behaviour (supportive, empathic, non-judgmental attitudes without collusion; being confident about discussing substance use with patients; appropriate action on worries about one's own or colleagues' use of substances)

The Netherlands: the following competences apply for all workers in the field (Buysman 2006):

1. Empathy, respect (e.g. imagining what the client's situation is like, coping with diversity of culture and ethnic background, coping with different age groups)
2. Effective communication and collaboration with the client (e.g. making contact, creating rapport, being able to collaborate with clients, negotiating with emancipated clients, keeping boundaries, not taking on the client's responsibilities)
3. Overview, structure (e.g. being able to work in a structured and systematic fashion, keeping track of main issues, knowing which colleagues work with what modules)
4. Result focused (e.g. being able to work in a result-oriented way, reaching set targets in set time, being responsible for result and quality, entrepreneurial attitude)
5. Multidisciplinary cooperation (e.g. being able to work in multidisciplinary teams, being able to give and take feedback, asking colleagues for help)
6. Networking (e.g. knowing the social map well, keeping in touch with other institutions, knowing when to refer)
7. ICT-competences (e.g. having insight in and being proficient in modern communication technology, computer skills, e-mail and internet)
8. Ability to learn (e.g. being conversant with latest developments, knowing where to get knowledge, having an open attitude, increasing learning capabilities, knowing one's own strengths and weaknesses)
9. Flexibility, suppleness (e.g. postponing judgement, coping with uncertainty)
10. Motivation and affection (e.g. motivating yourself, keeping affinity with job even in difficult situations, being glad with small steps, not having 'saviour' ideals, perseverance, coping with setbacks).

7.2.1 Prevention

Knowledge and skills to be learned:

- Primary, secondary and tertiary prevention in regard to consumption, abuse and addiction
- Setting up targeted prevention programmes (primary prevention at school, community based, etc.) and specific evidence-based programmes
- Early detection and intervention programmes and specific evidence-based programmes
- Methodologies of intervention, including interdisciplinary and interinstitutional collaboration
- Specific skills for conceiving, planning, implementing and evaluating prevention projects and programmes
- Special issues: access to special target groups, gender, migration, etc.

Examples:

USA: Penn State Continuing Education offers a certificate in addiction prevention. Admission requires a bachelor's degree from an accredited undergraduate institution, or a college senior with a grade point average of 3.5 or higher. The training covers: interview techniques, assessment skills, treatment plans, treatment modalities, impact on family, self-help groups, group facilitation, prevention methods, pathways to abuse and skills to work with high-risk persons (Penn State 2013).

Canada: Mount Royal University in Calgary, Alberta, offers an Addiction Studies Extension Certificate. The required courses are: Introduction to Addictions Perspectives; Drugs, how they work, their effects; Community based prevention; Family and Addiction; Working with adolescents; Special topics in addiction. The courses (120 hours) can be followed in the classroom or online. The certificate must be obtained within three years (Mount Royal 2013).

Greece: The Educational Centre for the Promotion of Health and Prevention of Drug Abuse (a programme of the University Mental Health Research Institute) was created with the collaboration and financing of the Organisation Against Drugs (OKANA) in order to provide basic training to prevention staff, produce information and training material for local prevention trainers, and train

staff in specialised domains, such as prevention programme implementation in primary schools. The Centre was active during the period between 1995 and 2006 following which it was closed. OKANA has established the Educational Centre, which organises training sessions for professionals and volunteers in all areas of demand reduction.

7.2.2 Treatment

Knowledge and skills to be learned:

- The different therapeutic models and their effectiveness in regard to addiction, including outpatient and residential treatments, with or without substitution
- Which treatments, for which patients, with which results: evidence-based interventions
- Psychopathologies linked to addictions and psychiatric and social co-morbidities
- The stages of change according to Prochaska and Di Clemente
- Training for motivational interviewing and relapse prevention
- Methods for assessment, treatment planning, crisis handling and evaluation of treatments
- Substitution treatments: legal framework, objectives, planning and evaluation
- Special issues: access to treatment, continuity of care, networking, integration of family, gender, migration, prison setting, minors

Examples:

Finland (Heinälä 2005): The Finnish Medical Association introduced in 1994 a credentialing programme that assures the public that the holder has the pre-requisite knowledge and competence to practice in that particular field within the confines of his or her medical licence. Addiction medicine was one of the first specialties to be acknowledged as an entity overlapping various medical specialties.

The objectives of the education: The field of addiction medicine requires knowledge of various medical disciplines and the understanding of the interactions if these disciplines. In order to ensure that the trainee is well versed in these areas, training programmes must include both versatile clinical experience as well as seminar sessions in the recognition of:

- Theoretical knowledge of preventive measures and therapeutic approaches in substance use and addiction
- Practical skills of independently working in organisations providing services for diagnosing and treating various addiction syndromes and other drug-related problems in health and social services
- Basic prerequisites for developing educational and research projects in the substance use and addiction field

Criteria of eligibility for the credentialing process: The trainee must apply for registration in the educational process as soon as possible in his or her professional career. The certification board will review the individual training plan and nominate the senior doctor in charge of supervising the trainee. A logbook is mandatory to document the versatility of the educational process.

Clinical training: A minimum of two years of supervised clinical training is required in a training centre providing alcohol and/or drug treatment services. It is recommended that experience in working in both ambulatory and inpatient services is included in the curriculum.

Theoretical education: A minimum of 200 hours of supervision, clinical case presentation and education in the treatment institute is required. In addition, 60 hours of participation in scientific seminars is mandatory.

Examination: The examination is composed of six questions of case presentations testing theoretical knowledge and clinical judgement. The examination will be proctored by the certification board. The questions and answers will be published immediately after the exam for participants in the exam and other trainers.

USA: The American Society of Addiction Medicine offers a certification examination to physicians who have completed residency training and an additional year of clinical experience in treating substance use disorders. The ASAM examination is offered every two years, with recertification required every 10 years
(http://www.asam.org/Certification_home.html).

Further examples:

- The Dutch System and Policy In Continuing Education in Substance Abuse Management (National Council for Competence Building at GGZ Netherlands)
- The Australian system of continuing education (Roche 2005)
- National consensus standards for postgraduate medical fellowship training in alcoholism and drug abuse in the USA (Galanter et al. 1991)
- Training Physicians to Treat Substance Use Disorders in the USA (Polydorou et al. 2008)
- A four-year curriculum on substance use disorders for psychiatry residents in the USA (Ianucci et al. 2009)

7.2.3 Harm reduction

Knowledge and skills to be learned:

- Risk reduction as part of public health policy
- Evidence-based intervention programmes
- Methods and tools of intervention in reducing risks
- Specific skills for conceiving, planning, implementing and evaluating risk reduction programmes
- Methods for passing on information relating to risks linked to health (HIV, hepatitis, hygiene, nutrition, exercise, etc.) for special target groups
- Methods of early detection and intervention
- Peer work, street work, mediation and advocacy
- Managing violence and the dynamics of groups
- Managing low-threshold service centres
- Programmes for reducing risks in prison
- Special issues: access to special target groups, access to social and health facilities, networking, gender, migration, etc.

Example:

> *Canada:* The Certificate in Harm Reduction consists of 117 hours of instruction designed to introduce service providers, administrators and policymakers to the principles, concepts and practices of harm reduction, to provide an opportunity to critically examine examples of harm reduction work, and to become familiar with strategies for mobilising support for and developing harm

reduction programmes in communities, families and institutions. Participants who complete all evaluative components will receive a Certificate in Harm Reduction from York University (York University 2013).

The intended audience for this initiative is a broad range of practitioners, administrators and policy advisors/analysts interested in better understanding and implementing harm reduction policy/practice within their organisation and work setting, including health care professionals (doctors, nurses, nurse practitioners), teachers and school administrators, counsellors, therapists, addiction workers, social workers, social service workers, administrators and board members, policy analysts, politicians, advocates, participants, criminal justice professionals, law enforcement officers and others.

The purpose of this initiative is to provide participants with:

- An understanding of the basic principles, philosophy and application of harm reduction (as a strategy for working with individuals, families and communities)
- Skills needed to critically analyse a broad range of examples of harm reduction programmes, policy and practice
- Strategies for mobilising support for harm reduction in communities, families and institutions, developing programmes, helping shape policy, and coping with resistance.

7.2.4 Continuing education for specialists

The addiction field is constantly evolving (new substances, new ways of consumption, new patient profiles, new scientific evidence, new laws, etc.), so it is important to provide a wide range of continuing education to update the specialists' knowledge and skills.

Examples:

The Netherlands: The following competences are considered essential for the continuing education of addiction specialists (Buysman 2006):

1. Related to substances (e.g. knowledge of substances, knowledge of psychopathology and medication, being able to notice physical complaints, being able to notice mental complaints, being able to assess the mental or physical condition quickly (diagnosis))

2. Behavioural interventions (e.g. being able to motivate, being able to use motivational techniques, being able to use behavioural interventions (relapse prevention management))
3. Use of new insights and methods (e.g. working with protocols, working along evidence-based lines)

International: The Treatnet project of the United Nations Office on Drugs and Crime (UNODC), in a first phase starting in 2005, involved staff from 20 resource centres in 19 countries in a comprehensive training programme and set up workgroups to produce best practice papers on specific issues. Packages with modules for training trainers were developed and supported the resource centres in their role as trainers for other services in their respective regions; the packages cover assessment, psychosocial treatments, pharmacological treatments and an administrative toolkit. A second phase, based on the evaluation of the first one, is dedicated to consolidation and expansion to 36 resource centres and over 60 partner centres in 27 countries. The project combines advocacy, capacity building and service improvement (UNODC 2011).

7.3 Education and training for occasionals

To be complete, training and education in addiction policy should also address occasionals. Occasionals do indeed have a first degree in their area of interest, but this does not cover the issue of addictions in depth, as it does not need to do so. However, addicted patients are not only treated for their addiction, but interact with many different health and social providers. These professionals are often overburdened with such cases. Their responses to these patients are often unfair, or even not respectful of basic human rights, and moreover very ineffective from a professional standpoint as well as on the outcomes of the whole health and social system.

Examples:

Australia: Most courses are developed to cater for multidisciplinary or cross-disciplinary interests. But there are a few exceptions to this; for example, pharmacotherapy training for medical practitioners caters specifically to doctors and pharmacists. Another exception is in relation to groups such as the police. Over the past decade, the police in most states in Australia have developed and implemented a wide range of AOD training courses for officers at different levels within the police force. Australia has

also established a specific graduate level AOD course for nurses. This can be undertaken as a distance education course and therefore caters to nurses across the country (Roche 2005).

USA: A collection of concrete projects in collaboration with non-specialised health and social services and their evaluation is presented in a comprehensive volume (Miller and Weisner 2002).

7.4 Education and training for voluntaries

Voluntaries are often through one way or another very close to the patients they want to help. This aspect should be addressed along with specific professional issues of their functions in daily work or with their relation to patients.

Example:

Germany: Specific professional skills for voluntary workers' further education are mainly offered through organised self-help. This includes semi-professional further education and continuing education for voluntary helpers, leaders of self-help groups and functionaries of abstinence and self-help associations. One example is the Good Templars who offer further education to volunteer addiction helpers. Seminars and courses of altogether 130 hours are conducted. This further education does not prepare for a full-time job in the addiction self-help field; it methodically teaches important and necessary knowledge in the field of voluntary help. In the foreground are the reflection of one's own attitude, limits of the possibilities to help, knowledge about alcohol and drug difficulties, structures and cooperation partners within the help system. At the end of the training the participants take part in a colloquium and have to present a theoretical assignment. For this the association issues its own certificate. Further education in other self-help associations is designed in a similar way organisationally and as regards content (Meyer 2005).

7.5 Education and training for societals

For the general public, awareness raising and appropriate information from media and opinion leaders is essential, in order to change prejudice and stigmatisation, to facilitate public discussion before voting, etc.

For specific members of society, it is helpful to organise continuing education events, for example for persons involved in shaping or implementing drug policies. The translation of evidence based on scientific knowledge into solid and effective policies and programmes at the state, regional and local level is only as successful as the knowledge and skills of drug policy managers who ultimately implement and administer these policies and programmes.

Example:

> The Pompidou Group has developed Executive Trainings for Drug Policy Managers, based upon needs assessment and evaluated for its effects. The 2013 Executive Training seeks to link policy, research and practice to develop specific tools to better reach the target groups of different ethnic populations. As the cooperation of law enforcement agencies and national immigration services with social and health care institutions is a crucial issue in dealing with regular and irregular migrant populations, the aspect of cooperation between different sectors will be focused on as well (PG 2013).

7.6 Reflection of attitudes

Personal attitudes are of greatest relevance by working with addicts. Having a wrong attitude towards them induces a counter-attitude that has a significant influence on the efficiency of therapeutic relationship. Reflection of attitudes should therefore be an integral part of many efforts in education and training. It does not only concern specialists, but also occasionals and voluntaries. The following issues should be reflected:

- Own perception of addicts and personal beliefs on addiction
- Substance use and addiction in one's own family
- Co-dependency patterns

Role-play is an appropriate technique to tackle this issue. Knowledge alone is not sufficient for one to become aware of personal attitudes and to be able to change them.

8

Implementation of policy and programmes

The following questions and examples stem from the survey publication based on the I-ThETA country reports (Uchtenhagen et al. 2008), which are still valid today.

The questions for implementation are: Should the system be directed in any way? If so, by whom (government, administration, NGOs, professional associations) and how (national or international coordination, financial support, setting of standards, educational policy goals, recognition and certification of qualifications acquired)?

8.1 Direction of policy and programmes

Should the system be directed or coordinated by a central authority or left to the free market?

Examples:

> The systematic provision of CET is directed in Scotland by the Scottish Executive and in Greece by three mandated institutions (the Organisation against Drugs (OKANA) for planning and funding, the Educational Centre for the Promotion of Health and Prevention of Drug Abuse for prevention, and the Therapy Centre for Dependent Individuals (KETHEA) for treatment). National plans, which are still in preparation, are directed in Austria by the Ministry for Health and Women, and in the Netherlands by a Government-commissioned national council. In other countries, some direction is provided through provincial executives (the Länder in Germany) or through a Government-appointed expert committee (in Switzerland). In some countries, the medical profession has started separate systematic postgraduate education for addiction.

8.2 Form of programmes

In what form should CET be provided?

- *Off the job: seminars, courses, curricula*
- *On the job: training, job rotation*
- *Near the job: project work, quality circles, E-learning*

Examples:

> Most CET is provided off the job (courses, workshops, seminars, curricula etc.), while additional on the job training is part of CET in a number of countries (Austria, Finland, France, Switzerland, and the USA). All forms, including near the job opportunities, can be noted in Switzerland and the USA. There is a tendency to develop special postgraduate curricula in addictology for nurses, social workers, psychologists, medical doctors (Netherlands, Switzerland). Another trend is the development of guidelines, 'good practice' concepts and manuals for prevention and treatment, for teaching purposes and for practice (Germany, Netherlands, Scotland, Switzerland, Australia, and the USA).

Offering a large variety of forms of CET gives the opportunity to cover a great deal of needs.

8.3 Positioning of courses and curricula

At what level of the national educational system should the courses and curricula be positioned? This question is closely related to the question of who are providers for courses and curricula. The answers to these questions have an important strategic issue for the addiction field because they influence its status in society.

Example:

> Switzerland: A Master of Advanced Studies is provided by a technical university that respects the formal ECTC standards. Professional associations and NGOs provide short courses oriented on new developments in the field of addiction.

8.4 Formal quality standards and guidelines

Does CET (whether individual courses, curricula or programmes) and/or institutionalised providers have to satisfy quality requirements, and who defines these requirements?

Examples:

No generalised quality requirements have been established in any of the participating countries of the survey. Such requirements are planned however in two countries (Austria, the Netherlands). Partial regulations for specific fields/professions exist in five countries (Germany, Greece, Switzerland, Australia, the USA), mostly established by the respective professional associations.

Are the contents of CET programmes directed by national guidelines (general concept) as a reference point?

Examples:

No country in the survey has national guidelines covering the contents of CET. One country is in preparation of guidelines and has already developed a concept for addiction-specific continuing education in substitution treatments for medical doctors, clinical psychologists, psychotherapists and social workers (Austria). Two country reports mention also that in specific fields/professions such guidelines are available (Germany, Greece).

8.5 Planning of programmes and evaluation

Is a circular process of defining needs, developing programmes and evaluating results, and vice versa, intended?

Examples:

Such a circular process is mentioned in only one report (Scotland), whereas three countries have it for special fields/professions only (Austria, Australia, the USA).

Should evaluation be an integral part of CET? By whom and how should the quality of CET be evaluated?

Examples:

As a rule, evaluation is in the hands of CET providers (self-evaluation). This is the case in eight countries (Austria, Germany, Italy, the Netherlands, Switzerland, Australia, the USA), with some differences in the frequency and level of professionalism. An absence of evaluation is noted in one country (France).

8.6 Leading professional role

Which occupational group should have a leading role, in terms of both of their work with addicts and in CET?

Examples:

A leading role of the medical profession is mentioned in five reports (Finland, Germany, Switzerland, Australia, and the USA). Cooperative leadership is preferred in two countries (Austria, Scotland); for the rest, the situation is not clear.

Should programmes be developed on an occupation-specific or a cross-occupational basis (inter/multidisciplinary or inter/multi-professional)?

Examples:

Mainly multidisciplinary CET is noted in one country (Australia), while both models are practiced in six countries (Austria, France, Italy, Scotland, Switzerland, the USA), and in two countries there is no mention of interdisciplinary training (Finland, Germany).

8.7 Courses for occasionals

How should CET be provided to non-specialist professionals in health and social services (occasionals)?

Examples:

There is no conceptual or practical approach mentioned how best to inform and train this target group and thereby to increase coverage of good practice for those in need of care and treatment. Experience from projects showing how to close this gap is available by now and needs to be introduced into education and training. The need is recognised in the UK workforce development plan of 2006: 'The purpose of this plan is not to impose a model of working in the substance misuse field, but rather provides a conceptual framework for the broad workforce required to implement the national drug strategy. It endeavours to set out … our plans to work with colleagues in related sectors to incorporate working with substance misuse into their mainstream agenda' (NHS 2006).

8.8 Financial aspects of programme implementation

The questions concern the funding of curricula development and programme development, of learning opportunities (seminars and workshops etc.), needs assessment and evaluation (including instrument development), and examinations and administration.

Should financial support be available to providers of education and training, or to trainees, or to services delegating the trainees, and in which proportion? Do quality standards apply as a requirement for funding?

Examples:

Financial support in general is available in Greece (see below) and Scotland, partially in Germany, Switzerland and Australia, but very limited in France, Italy, the Netherlands and the USA. The funding models are quite diverse. However, in most countries funds are available mainly for providers of CET, not for professionals and not for services engaging in CET (Uchtenhagen et al. 2008).

In Greece, training of demand reduction professionals is fractional and not well coordinated. Every agency allocates part of its own budget to train their staff, mainly on their own premises, and according to their own philosophy and needs.

The Action Plan for Combating Dependence 2011-2012, which was drafted by the National Committee for the Coordination and Planning of Drugs Responses, foresaw training of professionals and the establishment of the OKANA Educational Centre, which was established and has been working since 2011. The Centre has adopted state-of-the-art demand reduction training and addresses all professionals, not only OKANA staff. Training is also organised by drug demand reduction agencies, making use of the funds from the National Strategic Reference Framework (NSRF)

The findings from country reports of the I-ThETA survey demonstrate the major diversity in concepts and implementation of education and training in substance use matters, in almost all aspects. The reports also reveal a substantial deficiency in a systematic organisation and integration into a drug policy framework at country level.

9 Summary and recommendations

The enormous burden of substance use worldwide and the deficiencies of services in many countries (as far as reliably researched), clearly demonstrate the need for more efforts to improve service delivery, including efforts to improve the transfer of knowledge into practice.

It is therefore timely to consider the following recommendations:

1. The objective of training and education in substance use disorders should be taken on board by international organisations such as UNODC, WHO and the EU.
2. Education and training on substance use disorders should be embedded into a national Drug Policy.
3. Education and training on substance use disorders should also be embedded into a national education system through national action plans developed either by the education, health or research departments.
4. Education and training on substance use disorders should be based on national needs and also on changes occurring at international level.
5. Education and training on substance use disorders should be updated regularly to include the new elements that come to the fore.
6. Education and training should be evidence based and therefore the curricula should evolve accordingly.
7. Education and training on substance use disorders should be adapted to national priorities.
8. Education and training on substance use disorders needs to be evaluated.
9. Education and training on substance use disorders requires proper funding and qualified human resources.
10. Education and training on substance use disorders needs to be adapted according to the different requirements of respective target audiences.
11. Education and training on substance use disorders needs to take into account the complexity of the drug phenomenon and provide for multi-disciplinarity.

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Appendix I

Text of the resolution adopted at the 57th CND Session

Commission on Narcotic Drugs
Fifty-seventh session

Vienna, 13-21 March 2014
Agenda item 9

Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem: follow-up to the high-level review by the Commission on Narcotic Drugs, in view of the special session of the General Assembly on the world drug problem to be held in 2016

Greece,* Israel and Peru: revised draft resolution

** On behalf of the States Members of the United Nations that are members of the European Union.*

Education and training on drug use disorders

The Commission on Narcotic Drugs,

Recalling article 38 of the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol,[1] according to which parties to the Convention shall give special attention to practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved a nd shall coordinate their efforts to those ends,

Taking note of the conclusions and recommendations of the International Narcotics Control Board, including as contained in paragraph 53 (a) of the re
ve the
concerted actions by the international community to advance shared responsibilities in drug control, Governments should develop more effective practices to reduce illicit drug demand, focusing on education, prevention, treatment and rehabilitation, and should devote greater attention to the basic requirement of preventing first use of drugs,

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[1] United Nations, *Treaty Series*, vol. 976, No. 14152.

[2] *Report of the International Narcotics Control Board for 2012* (United Nations publication, Sales No. E.13.XI.1).

Recognizing the urgent need for better training and education of those people who work in the area of treatment of drug dependence, so that they may gain an understanding of the problems relating to the misuse and abuse of narcotic drugs and psychotropic substances and of the prevention of drug dependence, and through effective implementation of article 20 of the Convention on Psychotropic Substances of 1971,[3]

Recalling its resolution 48/7, on competencies required to address drug abuse, in which it recognized that developing human resources is an important element in countering the devastating impact of drug abuse,

Recognizing the major impact on public health, and the social and economic well-being of individuals and society at large, of dealing with drug use disorders as preventable and treatable medical conditions, and noting the absence of corresponding minimum standards for training on treating drug dependence,

Noting that scientific evidence from the World Health Organization and the United Nations Office on Drugs and Crime indicates that drug dependence is a preventable and treatable health disorder, resulting from a complex multifactorial interaction between repeated exposure to drugs and biological and environmental factors, and underlining that best results are achieved when a comprehensive multidisciplinary approach is adopted in order to respond to different needs,

Recognizing that multiple skills and scientific knowledge are necessary in order to effectively address drug use disorders with a comprehensive, balanced and scientific evidence-based approach,

Taking into account that integration of multidisciplinary training in the treatment of dependence may not be given appropriate consideration in some countries in the official training curricula for those providing relevant services to people affected by substance use disorders,

Stressing that training based on scientific evidence and education with supporting organizational structures, procedures and resources may improve success rates in prevention and treatment programmes,

Underlining the need to promote an innovative and integrated approach, based on interdisciplinary scientific evidence in the field of narcotic drugs and psychotropic substances, in order to promote expertise in dealing with various forms of addiction,

Taking into consideration the Declaration on the Guiding Principles of Drug Demand Reduction,[4] adopted by the General Assembly at its twentieth special session, according to which States should place appropriate emphasis on training

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[3] United Nations, *Treaty Series*, vol. 1019, No. 14956.

[4] General Assembly resolution S-20/3, annex.

policymakers, programme planners and practitioners in all aspects of the design, execution and evaluation of demand reduction strategies and programmes,

Bearing in mind that successful prevention, treatment and care may require valid methods, various approaches and evaluation, and that the availability of competent, skilled and experienced staff and professional competence requires continued research-based education and training,

1. *Invites* Member States, in accordance with domestic legal systems and national legislation, to further strengthen professional knowledge and skills for those working with, or intending to work with, people affected by substance use disorders by providing comprehensive scientific and evidence-based education and training programmes;

2. *Calls upon* Member States, through bilateral, regional and international cooperation, where appropriate, to collaborate in the provision of evidence-based education and training programmes by providing all types of assistance, including but not limited to technical assistance, upon request, in order to improve their ability to attain this goal;

3. *Highlights* the importance of strengthening the capacity of competent and appropriately experienced trainers to deliver training for those working with, or intending to work with, people who are or might be affected by substance use disorders;

4. *Encourages* Member States to promote a comprehensive approach to the study of substance use disorders, from the substance, health and behaviour perspectives, in order to better understand and tackle the issue on the basis of scientific evidence and to ensure its reflection, as appropriate, in educational and training programmes;

5. *Recognizes* the importance of an interdisciplinary approach to the development of such educational and training programmes, based on scientific evidence in areas such as medicine, psychology, education and the social sciences;

6. *Emphasizes* the need to further promote the quality and availability of education and training and to strengthen, where appropriate, intersectoral collaboration involving, inter alia, health and law enforcement professionals, as well as civil society, in accordance with domestic law and legal frameworks;

7. *Recognizes* the importance of continual quality assurance with regard to training, including its regular monitoring, evaluation and subsequent supervision by relevant certified professionals, working under the domestic law and legal framework and in accordance with applicable legislation and existing regulations;

8. *Encourages* Member States to share best practices in the field of education and training on drug use disorders and to work with the United Nations Office on Drugs and Crime in implementing the present resolution.

Appendix II

Pompidou Group publications from the Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs

- **Reflections on the concept of coherency for a policy on psychoactive substances and beyond**
  by Richard Muscat, Brigid Pike and members of the Coherent Policy Expert Group
  (ISBN 978-92-871-7345-4), March 2012
- **Treatment systems overview**
  by Richard Muscat and members of the Treatment Platform of the Pompidou Group,
  ISBN 978-92-871-6930-3 October 2010
- **Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis** by Richard Muscat, Dike Van De Mheen and Cas Barendregt,
  ISBN 978-92-871-6295-9 October 2010
- **Signals from drug research**
  by Richard Muscat, Dirk J. Korf, Jorge Negreiros and Dominique Vuillaume
  [ISBN 978-92-871-6694-4], Strasbourg, December 2009
- **The 2007 ESPAD Report: Substance use among students in 35 European countries** by Björn Hibell, Ulf Guttormsson, Salme Ahlström, Olga Balakireva, Thoroddur Bjarnason, Anna Kokkevi, Ludwig Kraus, The Swedish Council for Information on Alcohol and other Drugs (CAN), The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Council of Europe, (Pompidou Group)
  [ISBN 978-91-7278-219-8], February 2009
- **From a policy on illegal drugs to a policy on psychoactive substances**
  by Richard Muscat and members of the Pompidou Group Research Platform
  [ISBN 978-92-871-6480-3], Strasbourg, January 2009
- **Cannabis in Europe: Dynamics in Perception, Policy and Markets**
  by Dirk Korf (ed.) and the European Society for Social Drug Research (ESDD)
  [ISBN 978-3-89967-512-2] 2008
- **Old and New Policies, Theories, Research Methods and Drug Users across Europe**
  by by Zsolt Demetrovics, Jane Fountain, Ludwig Kraus (Eds) and the European Society for Social Drug Research (ESDD)
  [ISBN 978-3-89967-583-2] 2009

- **Pleasure, Pain and Profit. European Perspectives on Drugs**
  by Tom Decorte and Jane Fountain (Eds) and the European Society for Social Drug Research (ESDD) 2010
- **Market, methods and messages, Dynamics in European drug research**
  by Jane Fountain, Vibeke Asmussen Franck, Dirk J Korf (Eds)
  [ISBN 978-3-89967-741-6] 2011
- **The meaning of high, variations according to drug, set, setting and time**
  by Marije Wouters, Jane Fountain, Dirk J Korf (Eds) and the European Society for Social Drug Research (ESDD)
  [ISBN 978-3-89967-831-4] 2012
- **Risk factors in adolescent drug use: evidence from school surveys and application in policy** by Richard Muscat, Thóroddur Bjarnasson, François Beck and Patrick Peretti-Watel
  [ISBN 978-92-871-6196-3], February 2007
- **Drug treatment demand data – influence on policy and practice**
  by Hamish Sinclair
  ISBN 10:92-871-6086-4/ISBN 13:978-92-871-6086-7], October 2006
- **Psychological drug research: current themes and future developments**
  by Jorge Negreiros
  [ISBN-10:92-871-6032-5/ISBN-13:978-6032-4], September 2006
- **Biomedical research in the drugs field** by Richard Muscat
  [ISBN-10: 92-871-6017-1/ ISBN-13: 978-92-871-6017-1], July 2006
- **Drug addiction**, Ethical Eye Series, Council of Europe Publishing
  [ISBN 92-871-5639-5], July 2005 (to order from the Council of Europe Publishing: http://book.coe.int)
- **Connecting research, policy and practice – lessons learned, challenges ahead**, Proceedings, Strategic conference, Strasbourg, 6-7 April 2004
  [ISBN 92-871-5535-6]
- **Drugs and drug dependence: linking research, policy and practice – lessons learned, challenges ahead**,
  background paper by Richard Hartnoll, Strategic conference, Strasbourg, 6-7 April 2004
  [ISBN 92-871-5490-2]
- **Road traffic and psychoactive substances**,
  Proceedings, Seminar, Strasbourg, 18-20 June 2003
  [ISBN 92-871-5503-8], July 2004


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